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ABSTRACT

This paper presents a theory of shame development and resolution. Shame is a primary effect that is induced interpersonally. Shame inducement occurs when one significant person breaks the interpersonal bridge with another. Following internalization of shame within the personality, shame activation becomes an autonomous function of the self and the sense of shame lies at the core of one's identity as a person. Therapy needs to aim at dis-internalizing shame, enabling the client to effectively cope with the sources of shame without internalizing that effect, and enabling the client to affirm himself from within. Most importantly, within the therapeutic relationship, the therapist needs to return internalized, autonomous shame to its interpersonal origins, thereby reversing the developmental sequence. (Author)

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On Shame, Identity and the Dynamics of Change

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I had lived with shame all my life without knowing it as such. Though words come now, I never had words for shame and never understood its meaning until one day when Bill Kell related to me how a need that is not responded to appropriately converts to shame and then to rage. That began for me a process of discovering the significance of shame, a process I would like to share with you now.

The nature of shame can best be understood by differentiating its basic dimensions. First, shame is a primary affect. Second, shame is induced interpersonally in relation to significant others, originally parents. Third, after shame becomes internalized within the personality, shame activation becomes an autonomous function of the self and the sense of shame becomes a core part of one's identity as a person. In order for the therapeutic process to resolve internalized shame, these dimensions need to be attended to.

Shame: The Affect that Binds

At the level of affect, shame begins as the feeling of exposure. Some event suddenly focuses our attention upon ourselves and our eyes turn inward in painful scrutiny. We feel immediately exposed to ourselves and to others and may experience an urgent need to escape or hide. The feeling is one of torment or sickness within the self (Tomkins, 1963). Binding self-consciousness deepens along with feeling exposed, creating a paralyzing effect. Since shame is the experience of the self by the self, we experience ourselves totally as in no other affect. Shame can culminate in feeling alienated, defeated, lacking in dignity or worth.

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Shame Inducement: Breaking the Interpersonal Bridge

In my view, shame is inevitable when individuals interact precisely because we are human and therefore behave in ways that have unintended impact. Whenever someone becomes significant to us, whenever another's caring matters, shame becomes possible. Relationships evolve out of reciprocal interest and shared experiences of trust. An emotional bond begins to grow between individuals as they communicate understanding, respect and valuing for each other's personhood, needs and feelings included. That bond deepens along with trust and makes possible experiences of openness and vulnerability. The bond which ties two individuals together forms an interpersonal bridge between them. Emotional severing or breaking of that interpersonal bridge is the primary shame-inducing process (Kell, 1972, 1973; Bassos and Kaufman, 1973; Kaufman, in press).

When we become significant to another person, as happens when we are therapist, supervisor, friend, spouse, or parent, then we can induce shame in that other person, unconsciously, unintentionally, even without knowing it has happened. Failure to fully hear and understand the other's need and communicate its validity, whether or not we choose to gratify that need, can sever the bridge and induce shame. A client I worked with, Ted, once asked if we could go canoeing together. Instead of responding directly to his request I asked Ted "if going canoeing was a need or a want", implying that I would say yes to a "need" but not to a "want." He thought about it, decided his request was really a "want", and ambivalently dropped out of therapy.

Let us enter Ted's experience for a moment. Asking Ted to examine his request induced sudden self-consciousness and exposure. The resulting sense of shame deepened as he felt there was something wrong with his need or wrong with him as a person. Why else would his request not be responded to? The secondary

response Ted felt was fear of further exposure and he consequently backed out of our relationship. When I failed to approach him, Ted felt confirmed in his shame, which became a growing barrier between us since he could not risk exposure of his badness. Then, when I did make several direct approaches to him, Ted's overt response was rage.

Rage serves a vital self-protective function by keeping others away and insulating the self against further exposure and further experiences of shame. Unfortunately, the deep distress or feelings of hurt which may accompany shame also become encapsulated, hidden from view and inaccessible to therapeutic relief. Fear, rage and distress can be secondary responses to shame (Tomkins, 1973). The shamer initially is shown only the rage; others may or may not see the deep hurt and pain resulting from the ruptured relationship.

We may fail to respond appropriately to another's need in a great variety of ways. Simple oversight, lack of sensitivity or even well-intentioned criticism from significant others can convey the sense that one is not quite good enough as a person. Occasionally, our response involves disparagement, contempt, humiliation or a direct transfer of blame. Shame experienced under these conditions is far more intense and is accompanied by deeper rage and possibly longings for revenge. These are all instances of emotional severing between people in an on-going relationship. Since the interpersonal bridge is built upon certain expectations, rests upon learning to expect a certain mutuality of response, having these basic expectations of others suddenly exposed as wrong is a primary inducer of shame.

Shame Internalization: Shame Becomes Autonomous

I have discussed some of the ways we have at our disposal to induce shame in one another. The fact that shame is the experience of the self by the self, that

shame becomes a barrier to intimacy, and that shame is alienating and isolating are not sufficient to explain the significance of shame as a central motive in human development and interpersonal relations. The developmental theory of shame is based on the additional concept of internalization. After shame has become internalized within the personality as a major source of one's identity, the self becomes able to both activate and experience shame without an inducing interpersonal event. The self is then susceptible to shame irrespective of the external messages, good or bad, being communicated from others. In effect, shame becomes autonomous when internalized and hence, impervious to change.

Shame internalization is a development that is both gradual and complex. At least three distinct processes interact in leading to that outcome. First, periods of emotional pain increase susceptibility to internalization by making the self uniquely vulnerable. Both the external verbal messages communicated and other affects induced in the individual during moments of deep pain can become internalized as core affect-beliefs which help shape our sense of identity. A second process involves identification with the shaming parent. As Tomkins (1963) has argued, no wish of the child's is stronger than to be like the beloved parent. Modeling is one primary vehicle for such identification. We internalize not only what is said about us but especially the very ways in which we are treated by significant others, and we learn to treat ourselves accordingly.

The third way in which internalization is hypothesized to occur involves the development of specific affect-shame (Tomkins,1963) and need-shame binds within the personality. Whenever the expression of a particular affect, such as anger, crying in distress, or fear, is followed by a parental response which induces shame, an internalized affect-shame bind results. This affect-shame bind then controls later expression of that affect. For example, a child who is shamed for being afraid will learn that there is something wrong with him whenever he feels fear.

Situations which then arouse anxiety will autonomously activate shame, thereby binding that affect. Thus, a particular affect can now spontaneously activate shame without shame being directly induced. This enables shame to exercise a powerful indirect control over behavior. When all affects meet with shaming, a total affect-shame bind results, which only hastens the realization that one is shameful as a person.

Need-shame binds arise in an analogous manner. Learning to integrate one's basic needs is a developmental task which can be disrupted. Disturbances in intimacy, autonomy, sexuality, or dependency, to name a few, can result from either direct or inadvertent shame inducement. For example, sustained eye contact is a most intense form of interpersonal intimacy according to Tomkins (1963). Mutual looking very early becomes bound by shame when the child is shamed both for looking too directly into the eyes of a stranger and for being shy in the presence of a stranger. The need for human touching also is fundamental (Montagu, 1972). Physical holding is the child's natural request in response to emotional need or distress, however precipitated. Although holding can communicate security, restore trust, and re-affirm one's own well-being, all too frequently that need becomes bound and controlled by shame.

Internalization of shame means that the affect of shame is no longer merely one affect or feeling among many, which become activated and pass on. Rather, internalized shame is experienced as a deep sense of being defective and never quite good enough as a person. This affect-belief lies at the core of the self and gradually recedes from consciousness. In this way, shame becomes basic to one's identity. While the underlying affect is the same, the conscious experience of internalized shame differs widely. For example, feelings of inadequacy, rejection or self-doubt, feeling guilt-ridden or unloveable as a person, and pervasive loneliness are all conscious or semi-conscious expressions of internalized shame.

Internalization also means that the self can now autonomously activate and experience shame in isolation. Conscious awareness of limitations, failures, or simply awareness of not achieving a prescribed goal can activate paralyzing shame. There need not even be any external precipitating event. One client who felt terribly ambivalent about ending his marriage experienced acute shame when he approached a clerk to ask for a divorce application. That occasion forced him to expose his failure which activated his internalized sense of shame.

The varieties and depth of shame, a shameful identity in the form of an underlying sense of defectiveness, and autonomous shame activation by the self are consequences which stem from shame internalization. There is a fourth consequence, one which ensures that these three continue to reinforce one another so that shame becomes solidified within the personality. I have termed this consequence the internal shame spiral. A triggering event occurs. Perhaps it is trying to get close to someone and being rebuffed. The event could be either a critical remark from a friend or being blamed for something. It could even be simply not having anyone approach for several days or not being sought after or invited out. Either the event is in actuality shame-inducing (involving a current significant other breaking the interpersonal bridge) or the event autonomously activates shame. Either way, "When a person suddenly is enmeshed in shame, the eyes turn inward and the experience becomes totally internal, frequently with visual imagery present. The shame feelings and thoughts flow in a circle, endlessly triggering each other off. The precipitating event is relived internally over and over, causing the sense of shame to deepen, to absorb other neutral experiences that happened before as well as those that come later, until finally the self is engulfed. In this way, shame becomes paralyzing" (Kaufman, in press). This internal shame spiral is experienced phenomenologically as "tail-spinning", "spiraling downwards" or "snowballing." Each occurrence of the shame spiral can go on to include a reliving of previous shame precipitating events which thereby solidifies

shame further within the personality and spreads shame to many different people, events, situations, and behaviors.

Shame does not necessarily remain a conscious process. When shame does remain conscious, the sequence of events can happen so rapidly that clear recognition of those events by self or others is hindered. Gradually, defensive strategies evolve to enable the self to escape from and avoid paralyzing shame, particularly if intense exposure fears also develop.

Fear of exposure, one of the secondary responses to shame, is originally learned when the child's natural attempts to re-affirm the ruptured parental relationship are shamed again, however inadvertently. Exposure fear then operates to further encapsulate shame, hide it from view, and finally mask shame from consciousness. Frequently only the fear remains conscious. After internalization, exposure itself takes on a more devastating meaning. Exposure now means exposure of one's basic defectiveness as a human being. To be seen is to be seen as irreparably and unspeakably bad. Shame experiences become paralyzing partly because exposure itself eradicates the words. One feels speechless, trapped, helpless and utterly alone, though feelings of rage and omnipotence may soon follow. After shame becomes internalized a new shame experience, whether induced or activated autonomously, must be defended against, compensated for, or transferred interpersonally because exposure to others and to oneself has become intolerable.

Resolution of Internalized Shame: The Restoring Process

As long as shame remains internalized and autonomous, real change is prevented. New experiences with others, however positive, fail to alter one's basic sense of self unless the developmental sequence also is reversed. Such a reversal process is slow and painful, because intense fear of exposure and strategies of defense prevent access by the self or others to that most vulnerable core of the

self. Within the therapeutic relationship, internalized shame needs to be returned to its interpersonal origins. The self that feels irreparably and unspeakably defective needs to feel restored with the rest of humanity. The self that feels alienated, defeated, lacking in dignity or worth needs to feel whole, worthwhile and valued from within. If shame originates from an interpersonal severing process, resolution must involve a restoring process. If internalization develops from identification, from need-shame and affect-shame binds, and from periods of deep emotional pain which increase susceptibility to internalization, then dis-internalization must involve the offering of a new identification model, the dissolution of affect-shame and need-shame binds, and an experiencing of the emotional pain associated with defectiveness within the therapeutic process itself, provided that new affect-beliefs about the self can also become internalized.

At the outset of therapy, internalized shame is rarely assessible to consciousness. Those manifestations which are conscious are uniquely varied. Feeling inadequate or inferior, worthlessness and fears of rejection are some examples. One client always believed he was a stupid person. Another client feels like a failure interpersonally. Another feels angry at the whole world. Another has withdrawn himself into a cocoon of loneliness and defiantly refuses to come out. Distress and pain may not even be evident, since defensive strategies, such as striving for perfection, rage, contempt for others, striving for power, or internal withdrawal (Tomkins, 1963; Kaufman, in press), can so totally mask shame from view.

The therapeutic process, as Kell and Burow (1970) have described it, consists of the living out of a corrective emotional experience. Clearly, the therapist becomes significant in that endeavor. How that living out needs to occur in relation to shame is what I would like to make especially clear. The therapeutic processes necessary for the resolution of internalized shame can be most clearly understood by differentiating them one from another.

Interpersonal Bridging. We begin with building a bridge, an interpersonal one of course. The building of trust within the therapeutic relationship is slow and painstaking, since the original failures were early and deep ones. Building the interpersonal bridge gradually lessens the need for defensive strategies and makes possible experiences of vulnerability and openness between therapist and client, as Kell and Burow (1970) have observed. Mutual understanding, growth and change are thereby facilitated.

Once built, such a bridge needs to be maintained in a particular fashion in relation to shame. Bridging thus becomes an on-going process. Let me clarify. Shame feelings need to be actively approached and openly validated by the therapist. When this occurs, exposure fears become reduced, thereby enabling the client's awareness of his internal shame processes to deepen even further. In effect, the client learns an important interpersonal lesson, namely, that expression of shame will not be shamed again. Therapist approach and validation need to follow each time the client dips deeper into shame. Otherwise, the client will feel abandoned, shamed again or experience his shame as too threatening for the therapist. The dip for several clients of mine has gone so far as to involve intense fears of "going crazy." I have had to sit on my own anxiety and go with them into their inner experience in order for them to begin to feel restored. Thus, interpersonal bridging is the first basic, on-going process of the therapeutic endeavor, and both underlies and facilitates the remaining therapeutic processes.

Discovering the Original Sources of Internalized Shame. As the client's own awareness of shame gradually deepens through the bridging process, therapist and client increasingly are able to discover the original inducing events within the family. Our sense of worth and adequacy as human beings rests upon having certain fundamental needs responded to positively as we grow, thereby enabling us to feel secure in our personhood. Frequently, though certainly not always, shame internalization follows from parental rejection of the child's most fundamental needs, how-

ever unconscious that rejection may be. Such rejection may occur, for example, when one or both parents did not want the child at all or really wanted a child of the opposite sex. Shame can also be rooted in a parent looking to the child to make up for the parent's deficiencies, in looking to the child to literally be parent to the parent, or in wanting the child never to need anything emotionally from the parent--in a sense, to have been born an adult. (I am indebted to Dr. Sue Jennings, 1972, for the latter idea.) Or the child may simply have been born the wrong temperament for the sex; quiet, more introverted boys and outgoing, aggressive girls have traditionally fared less well in our culture because they fail to match the expectations of significant others. Rejection may be clear and open, ambivalent and hidden, or defended against by over-possessiveness and over-protectiveness. Finally, parental behavior can have unintended rejecting impact upon the child, through communicating failure to meet parental expectations, even when parental attitudes are not inherently rejecting.

Expanding awareness of and discovering the original sources of internalized shame, in conjunction with experiencing the emotional pain associated with defectiveness, together make possible the internalization of new affect-beliefs about the self. The developing new relationship with the therapist gradually enables the client to relinquish some of his old, shameful identity. And a new sense of identity tentatively begins to emerge.

Dissolution of Specific Affect-Shame and Need-Shame Binds. In these cases, rejection has been partial and specific to particular affects, behaviors or needs, whether that rejection was intentional or inadvertent. Affect-shame and need-shame binds need to be dissolved by making both the bind and its source conscious for the client. The need or affect itself also needs to be validated. This can happen by encouraging the client through new, perhaps frightening experiences outside of therapy that are themselves corrective. This also happens through living out corrective experiences within the therapeutic relationship. For instance, a client deeply ashamed of needing to be held may eventually ask to be held by the therapist.

Most frequently, such emotionally corrective occurrences are an on-going,often unnoticed, part of the therapeutic process.

Making Conscious the Link Between Shame and Strategies of Defense. Defenses against shame are adaptive. They have been the client's only ways of surviving intolerable shame. Strategies of defense aim at protecting the self against further exposure and further experiences of shame. Several of the most prominent strategies are rage, contempt for others, the striving for perfection, the striving for power, and internal withdrawal (Tomkins, 1963; Kaufman, in press). Both perfectionism and power-seeking are strivings against shame and attempt to compensate for the sense of defectiveness which underlies internalized shame. None of these are unitary strategies; rather, they become expressed in unique and varied ways, with several often functioning together. The therapeutic aim is not to eliminate those strategies but to enable the client to learn new, more adaptive ways of coping with the sources of shame. Gradually, the need for rigid defensive strategies lessens as their meaning in relation to shame becomes clearer to the client. As the client's tolerance for shame thereby increases, the powerful need to transfer interpersonally experienced shame also lessens.

Enabling the Client to Learn to Cope Effectively With the Sources of Shame Without Internalizing that Affect. Whenever a client expresses bad feelings about self, the therapist needs to attend not only to those feelings but to the source of those feelings as well (a differentiation also emphasized by Tomkins, 1963). If the source of bad feelings is the self's autonomous activation of shame following some past or current precipitating event, the therapist needs to enable the client to learn how to cope effectively with the sources of shame without internalizing that affect. There are many ways in which this occurs during the course of therapy. One way concerns the appropriate handling of the client's shame spirals. The therapist needs to enable the client to learn to recognize, intervene consciously and

terminate that internal shame spiral. Attempts at understanding the experience while it is spiraling or snowballing only embroil one deeper into shame. Deliberately focusing all of one's attention outside oneself by becoming visually involved in the world breaks the shame spiral and allows those feelings and thoughts to subside. Later, the precipitating cause can be explored and understood with one aim being, enabling the client to intervene even sooner in the future. The therapist can both intervene directly when shame is spiraling within the session, and enable the client to do likewise on his own. The client thereby gains active control over his internalized shame processes. In effect, the therapist helps the client know not only which bad feelings he needs to feel and which to let go of, but especially, how not to internalize them.

Equally basic to therapy, the therapist needs to provide the client with new ways of understanding his own experience which then enable him to free himself from the paralyzing effects of shame. Defeats, failures and rejections are inevitable in life. We need to learn how not to internalize the feelings of shame which naturally arise, while still being able to profit and learn from the very "mistakes" which may have contributed to those failures in the first place. One way Bill Kell did this was through the concept of "learning time." We need time to both make mistakes and live them out, without internalizing those mistakes as personal failures, precisely in order to gain eventual mastery. The therapist provides a very important, new identification model in this regard.

A client, Ron, was deeply troubled about intimacy. He believed that he was defective in not being able ever to sustain an intimate relationship. One session, Ron came in expressing much hurt and pain because the group living situation he had been heavily invested in was falling apart, due to one of the other member's conflicts. He began sobbing about this being a repeat of his other failures. I listened to his feelings of shame but I also pointed out to him that this time was different. Ron looked at me quizzically. I clarified for him that <u>this</u> time

he had stayed in the relationship long enough to learn that it was not his personal failure which was causing the problem. His tears dried up, he sat up in his chair and said "I'm done for today."

The sources of shame are not always externally based. They can be internal in the form of the self's own awareness of perceived limitations. Most frequently, we have learned to feel ashamed of those aspects of self which make us feel different from others. The therapist needs to enable the client to accept, perhaps even to find value in, those very aspects of himself which he finds most intolerable. Only then can change begin to occur.

Shame Inducement and Resolution Within the Therapeutic Relationship. If the source of shame lies within the therapeutic relationship, the therapist needs to recognize, hear and validate those feelings, even acknowledging his own part in producing them. When the therapist becomes significant to the client and the therapist's caring, respect and valuing begin to matter, the therapist himself becomes a potential inducer of shame. When he has induced shame within the client, however inadvertently, the therapist can restore the interpersonal bridge he severed by openly acknowledging his own part in that process. If the therapist, someone deeply valued, can acknowledge his imperfect humanness, even his part in making us feel shame, those shame feelings pass on. The growth impact is far greater than if the severing experience had never happened in the first place. When inducing shame is followed by restoring the bridge, internalization does not occur.

With one client, Martha, I had no idea anything was wrong until I received a letter from her expressing her intention to stop therapy though feeling much hurt, pain and rage. I called her and she decided to come in. Somehow she began to feel better about working with me, though still wondering if I really cared about her. The very next session was critical. We began fine but I gradually became a-

ware that something was wrong again. Then Martha began talking of terminating. What emerged, as we tried to understand the sequence, was that whenever I looked out of the window, Martha felt abandoned and rapidly withdrew inside herself. Shame and rage followed. I acknowledged my part, that is, I do like to look out the window but I did not intend to abandon her. I persisted in suggesting that somehow what I had done must also have happened before. Martha came in the following session having remembered similar occurrences with her step-father during childhood.

Developing the Client's Capacity to Affirm Himself From Within. The foregoing therapeutic processes interact with one another, gradually enabling the client to dis-internalize shame, to learn to cope effectively with those potential sources of shame to which he is uniquely vulnerable, and to begin to affirm himself from within. The capacity to affirm oneself and the evolving of a separate identity are mutually enhancing. Self-affirmation is facilitated by therapist valuing of the client's uniqueness as a person, by enabling the client to tolerate shame feelings, and by enabling the client to learn to cope with the sources of shame without internalizing that affect. Of necessity, self-affirmation continues after separation from the therapist, which usually involves termination of therapy but not necessarily termination of the relationship.

Realization of the self-affirming capacity integrates the self around a new core. The self gradually becomes a primary source of its own caring, respect and valuing, as it begins to recognize and value both our human communalities and those very things which make us uniquely different. Because the self can now continue feeling affirmed from within even in the face of defeat, failure or rejection, shame can remain a feeling which is activated or induced and then passes on. We always remain susceptible to shame. While the self continues being able to experience shame, it has begun to learn how not to internalize that affect. In effect, we have learned how to restore the bridge with ourselves.

Shame Development and Resolution: The Process in Summary

Shame is a primary affect that is induced interpersonally in relation to significant others, originally parents. Shame inducement occurs when one significant person breaks the interpersonal bridge with another. Such emotional severing results from failure to either recognize or fully hear the other's need as valid, from disparagement, blaming or direct humiliation of the other, or from having one's basic expectations about the world suddenly exposed as wrong.

The developmental theory of shame is based upon the concept of internalization. The process of shame internalization is both gradual and complex. Experiences of emotional pain are hypothesized to increase susceptibility to internalize directly shame affect-beliefs. The development of specific affect-shame and need-shame binds within the personality and identification with the shaming parent are hypothesized to be additional mechanisms of internalization. Following internalization, shame is experienced as a sense of being fundamentally defective as a person. Shame activation becomes an autonomous function of the self and the sense of shame becomes the core of one's identity as a person.

Based upon the foregoing developmental view, the general features of the therapeutic process necessary for the resolution of internalized shame are described. Therapy needs to aim at several interrelated goals, first, dis-internalizing shame, second, enabling the client to learn to cope with the sources of shame without internalizing that affect, and third, enabling the client to begin to affirm himself from within. The therapist needs to actively approach the client's internalized shame, validate those core affect-beliefs, and enable the client to both become aware of and actively gain control over his internalized shame processes. Mastery is also furthered through discovering the original sources of shame.

Most importantly, within the therapeutic relationship the therapist needs to return internalized, autonomous shame to its interpersonal origins, thereby reversing

the developmental sequence. Dis-internalization is facilitated whenever shame becomes induced and resolved within the therapeutic process. With dis-internalization, the client can move beyond internalized shame towards a self-affirming identity.

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